And If It Takes Lying: The Ethics of Blood Donor Non-Compliance

Sometimes, people who are otherwise eligible to donate blood are unduly deferred from donating. "Unduly" indicates a gap where a deferral policy misstates what exposes potential donors to risk and so defers more donors than is justified. Since the error is at the policy-level, it's natural and understandable to focus criticism on reformulating or eliminating the offending policies. Policy change is undoubtedly the right goal because the policy is what prevents otherwise safe eligible donors from donating needed blood. But focusing exclusively at the policy-level passes over a largely undiscussed question: if policy change takes time and there is an urgent need for blood now, then what should unduly deferred donors do in the meanwhile? Blood banks and federal agencies recommend that deferred donors donate their time or money until they become eligible, but blood is a non-fungible good: donated cash or volunteered time cannot replace a transfusion. Further, this request ignores that otherwise eligible donors could safely donate their blood in addition to their time and money. Here is the central question I will focus on in this paper: is a donor morally justified in lying on a questionnaire to donate blood if they justifiably believe that their blood poses no risk to a recipient and knows that honestly answering a donor questionnaire would unduly defer them from donating?

I start by analyzing why we use donor deferral policies in order to evaluate when they are (not) justified. I argue that deferral policies are justified only if the deferral conditions accurately stand in for later health concerns. I turn to a historical example, when the U.S. Food and Drug Administration (FDA) indefinitely deferred Haitian donors from 1984-1990, to show how deferral conditions can mismatch later tests: Haitian national origin wasn't predictive of having HIV. This mismatch is important on the policy level because it lets us distinguish between the stated deferral conditions and what I will call "ameliorative deferral conditions." Ameliorative deferral conditions

refer to the deferral conditions that a policy should use to parse risk and so are ameliorative in the sense that we are trying to realign the policy with the conditions that accurately correspond to health risks.

While ameliorative deferral conditions usefully guide policy discussions, I show in sections two and three how they can also pick out what unduly deferred donors are responsible for in order to justifiably believe that they do not pose a risk to recipients. This responsibility is epistemic and moral: epistemic because it describes what unduly deferred donors need to learn and how they can learn it; moral because accounting for the risks in question is about protecting a recipient. In section two I work through recent criticisms of the FDA's deferral policy for donors who are men that have sex with men (MSM) to accentuate that not knowing about or presuming a HIV-negative serostatus among MSM, rather than being MSM itself, is what constitutes the risk the deferral policy is ostensibly tracking. If MSM use a valid test to determine they are seronegative, then they are justified in believing that they do not pose a risk to recipients even though they are MSM. Although underdiscussed in the literature, I argue in section three that the deferral about tattoos has a slight gap between the stated and ameliorative deferral conditions. While state regulations about applying tattoos make it more likely that they are applied safely, what matters for the deferral is how donors with tattoos assess sanitary conditions about needle use generally. Clarifying when needle use is (not) sanitary identifies the ameliorative deferral conditions for the tattoo policy because it specifies when donors who get new tattoos would be justified in believing that their donation would not endanger a recipient.

I conclude in section four by examining some moral aspects of blood donation and non-compliance. A common background premise in discussions about blood donation is that it is a gift, freely given, and so is good to do, but not morally required. In contrast, Paul Snelling (2014) has

recently objected that donating blood is morally required. I introduce each argument and, instead of deciding the moral status of donating blood, I work through a real world example to show that whatever the moral status of donating blood itself is, unduly deferred donors typically take on a substantial risk when they lie to donate. Since lying is the only way for an unduly deferred donor to donate blood, and that lie exposes them to risk, I conclude that lying in order to donate blood is generally supererogatory.

1. Deferral Policies and the Haitian Deferral

The FDA uses an overlapping and multi-level system of safeguards to protect the blood supply. V.A. Armstrong (2015) observes that these measures balance safety concerns with efforts to increase the quantity of available blood while efficiently maintaining the system. As a result, these decisions need to balance financial cost, loss of donors, ability to find replacement donors, seriousness of the identified risk, and the likely change in risk by adopting, revising, or eliminating a policy (Custer et al. 2004). In addition to regulating the initial blood collection and maintenance processes, these policy decisions have a public face because they assure recipients and the general public (e.g., potential donors) that safety policies have recipients' best interest in mind and so only use the best available methods and data to track risk.

Start with donor eligibility. Before they donate, donors are asked a series of questions about their behavior and current health to determine if their donation would endanger a recipient. Donor questionnaires are an initial line of defense that preclude at-risk blood from entering the blood supply. Even though we test all of the donated blood, donor questionnaires are invaluable for a few reasons. First, healthcare systems have limited resources. Testing blood takes time and money, so if donor questionnaires can accurately identify at-risk blood that later testing would remove anyways, then there is a practical reason to defer that donor from donating. Second, contrary to

popular depictions in media, we don't just "run tests" that are all-inclusive for every possible health condition. Tests screen for particular conditions and selecting which tests to pay for depends on a number of demographic, environmental, and epidemiological factors. Currently, donated blood in the U.S. is not screened for malaria because malaria is not endemic to the U.S. Further, accurate testing for malaria can require a year after exposure because parasite densities can be dormant or too low to be detected. So, instead of testing every unit of donated blood for malaria in the U.S., we use a deferral based on donor travel to places where malaria is endemic.[1] Third, donor questionnaires cover conditions that would be difficult to test for, but would nevertheless endanger a recipient. Asking donors if they feel unwell on the day of their donation temporarily defers them without having to know what exactly is causing the malaise. Deferral policies, therefore, are an integral safety measure because they preclude at-risk blood from entering the blood supply in the first place and help the system run efficiently.

However useful deferral policies are in the abstract, what matters on the day of the donation is donor compliance. If donors do not honestly or accurately answer the deferral questions, then the deferral policies are not effective from either a safety or an efficiency perspective. People often misreport the truth about themselves in both ordinary and medical situations not because they are duplicitous, but because they are responding to expectations in those interactions. One common explanation for why we misreport information is social desirability bias. Social desirability bias is a complicated psychosocial phenomenon, but the basic idea is that a respondent identifies what the expected or socially approved answer to a question is, and then adapts their answer to that expectation rather than what is actually true. Social psychologists have found that people routinely misreport about both the mundane (e.g. amount of vegetables people eat, dental hygiene practices

[1]Kitchen and Chiodini (2006) juxtapose malaria policies between endemic and non-endemic countries.

(Miller et al. 2008, Moshagen et al. 2010)) and the sensitive parts (e.g. drug use, sexual activity (Rao et al. 2017, Latkin et al. 2016)) of their lives. If social desirability bias is this prevalent, then there is at least a *prima facie* concern about the deferral policies' efficacy.

While we can never wholly eliminate social desirability bias on the donor questionnaires, we can take steps to reduce it. Lowndes *et al*. conducted a study that found that respondents give more accurate information when they believe that their answers are confidential and provide even more accurate information when they believe that their answers are anonymous (Lowndes *et al*. 2012). While deferral questionnaires are not anonymous, they are confidential, so donors may be less vulnerable to social desirability bias about stigmatized behaviors. Additionally, respondents give more accurate answers when they believe that their answers are screened by a "lie detector," even if no such device is used (Lee and Woodliffe 2010). Since we regularly emphasize that all collected blood will later be tested anyways, donors know that they are subject to a "lie detector" and so are less susceptible to social desirability bias. Lastly, studies have found that respondents tend to give more accurate answers when they received a previous warning about the consequences or effects of faked results (Hough *et al*. 1990). More importantly for our purposes here, the nature of the warning increased accuracy (Dwight and Donovan 2003): reminding donors that recipients are the ones who bear the cost of faked results emphasizes the moral reason donors have to comply with the deferrals by honestly answering questions.

We do not have to justify deferral categories as a standalone safety measure because blood that is collected after the questionnaires is quarantined for later testing. The quarantine is useful because it catches cases where donors mistakenly self-report: someone may not know that she has hepatitis C or syphilis and so honestly misreport her health during the donor questionnaire. The quarantine complements both the questionnaires and the later testing because it establishes a

window period where the blood is held until a test could accurately detect the health risk the deferral question was asking about. The quarantine also shows that we only expect donors to answer deferral questions based on their justification. Even though the deferral questions are designed to protect recipients, we rightly do not think a donor is being reckless or morally fault them if their donation, unbeknownst to them as a result of reasonable behavior, turns out to be a health risk to recipients. By the same fact, if a donor's justification is connected to the recipient's health, then there is also a conditional moral responsibility: donating blood is only permissible if a donor justifiably believes that their donation will not endanger a recipient. Questionnaires, blood quarantine, and deferral periods are all revisable: increasingly accurate tests, as well as their availability, cost, and governmental approval, shorten both the window periods during quarantine and the time that a donor needs to be deferred. M. Goldman (2013, 2018) elaborates that since these policy revisions are made in the name of increasing safety to the recipients by more accurately assessing risk in donors, they are also subject to political pressure and legal challenges when the public doubts or mistrusts that rationale.

One justification for donor deferrals depends on the stated deferral conditions being a sufficiently accurate proxy for what the later tests are testing for. If the stated deferral conditions do not predictively match the later tests, then we need to revise the stated deferral conditions. When we are trying to revise a deferral policy, we are trying to identify the conditions that do accurately track what puts someone at risk: I'll call these conditions the ameliorative deferral conditions. If we can identify the ameliorative deferral conditions, then we should revise the policy accordingly. If, however, we cannot identify the ameliorative deferral conditions, then we have to acknowledge that the policy is not justified and so should be eliminated.

One of the most notorious cases where the stated deferral conditions had nothing to do with later testing was the FDAs indefinite deferral of Haitian blood donors. In 1982, U.S. the Centers for Disease Control and Prevention (CDC) determined that although Haitians were .3% of the U.S. population, they represented 6% of HIV/AIDS cases in the U.S. (CDC 1982a). The CDC went on to conclude that "Haitian origin" was an "identified risk factor" for AIDS and that the pronounced proportion of population to HIV infection rate warranted classifying Haitians as a distinct at-risk sub-group of heterosexuals (CDC 1982b 507-08, 513-14). Charlene Galarneau (2010a) explains that by 1984, the FDA implemented a deferral policy based on the CDC's findings that indefinitely deferred all Haitian immigrants from donating blood if they arrived in the U.S. after 1977.[2] The rationale for the stated deferral conditions was that being Haitian increased someone's likelihood of having HIV. Citing the amplification of HIV/AIDS infections, the FDA indefinitely deferred immigrants and revised the Haitian deferral in 1990, expanding it to defer all Haitian donors, regardless of the year of their immigration.

There are a number of reasons why the FDA's policy evolved the way that it did. First, there was a general panic about HIV/AIDS in the 1980s and 1990s that put citizens and public health officials alike on edge. Ignorance about HIV, especially about how it spread, compounded this fear, branding people with HIV/AIDS not just as "deserving," "irresponsible," or "cursed," but as serious threats to society (Bayer 1989). Second, Haitian refugees had been fleeing the Duvalier regime since the 1950s and had faced social, political, racial, and linguistic barriers coming to, and making a life in, the U.S. Galarneau (2010a) explains how these barriers not only marginalized Haitians, but also prevented Haitian self-representation, effectively erasing them from dominant political narratives. This lack of political representation meant that Haitians had

[2] Lauren Leveton, Harold Sox Jr., and Michael Stoto (1995) provide a detailed history of the rise of HIV in the US blood supply and the various reactions to manage both the risk and public uncertainty about blood safety.

few public health advocates at the policy level and so were easy scapegoats. Third, Amy Fairchild and Eileen Tynan document how domestic racist tropes about blacks being sexually promiscuous were "compounded by the exotic: a foreigner practicing voodoo, fantastic sexual rituals, or cannibalism, all of which intimate an unnatural exchange of blood" (Fairchild and Tynan 1994, 2014). Fairchild and Tynan make the case that this connection, between stereotyped Haitian culture and perceived public health risk, explains why the CDC did not just conclude that a number of HIV/AIDS cases happened to coincide with donors who happened to be Haitian. The imposed cultural "otherness" presumed Haitians were essentially different. That racialized presumption prejudiced how the CDC and FDA interpreted the pronounced HIV infection rate among Haitians as evidence for why Haitian became a FDA approved sub-category of risk for HIV-infection.

We can recognize the mismatch between the stated deferral conditions and what later tests were testing for. If Haitians were classified as an at-risk sub-category of heterosexuals, then the stated deferral condition pinpointed the risk for contracting HIV in virtue of Haitian national origin instead of any behavioral deferral conditions. Since there is nothing in virtue of being Haitian that puts someone at risk for contracting HIV, the Haitian deferral questions stated conditions that did not accurately predict what later tests were testing for. This mismatch did not go unnoticed. From the beginning, the Haitian community disputed the stated deferral conditions, objecting that no one gets HIV just by being Haitian. When the FDA expanded the Haitian deferral policy in 1990, more and more people began to protest that it was both medically and morally unjustified (Farmer 2006; cf. Pepin 2011). This pressure prompted the FDA to convene the Blood Products Advisory Committee to reassess their Haitian deferral policy and came to the near unanimous conclusion that they should rescind the policy (Galarneau 2010a, 214-16).

This clipped history of the Haitian deferral policy shows a not too distant example when stated deferral conditions were not predictive of whether someone's blood would put a recipient at risk. The brief literature review also shows that while critiques (rightfully) focused on the policy failure, they pass over the question of what unduly deferred Haitians were morally permitted to do (in addition to protesting) while the unjustified policy was in effect.

I develop this point about additional action in the next two sections by considering two contemporary deferral policies that inadequately state what puts donors at risk. Unlike the Haitian deferral condition, however, the MSM and tattoo deferrals correctly identify that some donors are at risk because of the behavior that sorts them into those deferral categories. The reason, however, that these deferrals go wrong is because they treat donors in their respective deferral categories as uniform blocs and so fail to accurately articulate which conditions actually expose potential donors to the risks the policy purports to track. If we can identify the ameliorative conditions for these polices, then we have, *ipso facto*, identified what donors who are currently unduly deferred need to account for in order to be justified in believing that their donation will not endanger a recipient.

2. Current and Unjustified Deferrals

In 2015, the FDA revised its longstanding indefinite deferral of MSM donors to twelve months. The indefinite deferral rested on two ostensive claims: (1) an elevated rate of HIV and hepatitis C among MSM; (2) cumbersome HIV-antibody testing. Activists, bioethicists, and public health officials challenged the first justification, charging that the MSM policy was thinly veiled homophobia by unfairly singling out gay and bisexual men as the exclusive victims of HIV/AIDS (Fisher and Schonfeld 2010; Galarneau 2010b; Kesby and Sothern 2014). Ronald Bayer (2015) recounts that medical organizations began to withdraw their support for the second justification as

increasingly accurate tests for HIV became standard practice for screening blood. The FDA revised the MSM deferral in 2015, shortening it to twelve months.

Critics of the 2015 MSM policy revision acknowledged that it was a step in the right direction, but pressed that the FDA was still committed to either reducing the deferral from twelve months to whatever window period the tests warranted or eliminating the MSM deferral condition altogether in favor of a more general risk-based questionnaire, such as number of partners, HIV-status of partners, prophylactics use (Berkman and Zhou 2015; Blankschaen 2018). More recently, in 2020, the FDA further reduced the MSM deferral period from twelve months to three months. In response to an urgent need for blood during the COVID-19 pandemic, the FDA has also commissioned a study to review the efficacy of the MSM deferral condition. These developments seem promising, but they still pass over the question of what unduly deferred MSM donors should do in the here and now. In order to address this question, I take up what it means for a MSM donor to be unduly deferred and then develop that point into what an unduly deferred MSM donor would need to know before he decides to not comply with the current policy, regardless of whatever the policy ends up being.

Kurt Blankschaen argues that if the FDA cites an elevated risk for HIV among MSM as justification for their deferral policy, then any objection to that policy must account for what he calls "The Empirical Case" (Blankschaen 2018, 3-4). The Empirical Case draws on CDC surveillance data to determine if the elevated risk that the FDA is worried about in fact obtains for MSM. Although definite numbers are hard to come by, the CDC estimates that MSM are about 4-7% of the U.S. population (Purcell *et al.* 2012). CDC surveillance data routinely show that MSM continue to make up a disproportionate number of new HIV cases. The CDC's updated 2018 HIV Surveillance Report estimates 37,881 new HIV diagnoses in the U.S. Approximately 66% of those

HIV diagnoses (25,001) were due to male-to-male sexual contact and approximately 4% (1,515) were due to male-to-male sexual contact *and* injection drug use (CDC 2018a). Although The Empirical Case appears to corroborate the elevated risk the FDA cites, Blankschaen points out that it misstates what, exactly, puts MSM donors at risk.

In terms of health risk to recipients, what ultimately matters is if a donor has HIV. If neither man has HIV, then it does not matter how many times they have sex with each other. It is not, therefore, being MSM *itself* that constitutes the elevated risk. What then of The Empirical Case? Acknowledging the persistently high new HIV infection rates among MSM, Blankschaen proposes that we reformulate the current MSM deferral along the lines of what MSM donors justifiably believe about their serostatus at the time of their donation. Each new MSM category is partially constituted by a behavioral component (i.e. MSM) and partially constituted by an epistemic component (i.e. belief about serostatus).[3] This epistemic component matters from a risk-based standpoint because it evaluates how MSM come to believe they are seronegative, which implicates the moral impact of that belief: that the donor can justifiably believe that their donation will not endanger recipients.

Although this proposal identifies an ameliorative deferral condition to reform the policy, it can also guide how unduly deferred MSM donors who justifiably believe that they are seronegative can act until the policy is rewritten. The most reliable way for someone to know that they are seronegative is to take a HIV-test after a sufficient window period from their last point of exposure. Many of the HIV-tests used in free clinics or on college campuses are free, anonymous, and use

[3] Social metaphysicians (Haslanger 2012, Epstein 2015, Mallon 2016) have shown that many substantive social categories are heterogeneously constituted by, and responsive to, material, institutional, behavioral, and demographic changes in the social world. Identifying metaphysical features of a category, then, does not commit us to some timeless essence. Instead, clarifying the relevant metaphysical features of a category depends on the particular values we have and the problems we are trying to solve at a given point in time.

the same, if not longer, window period that the FDA uses, so MSM who use a test to determine if they are seronegative are using equivalent standards that would be used to screen their blood after the quarantine. Donors who use tests to learn that they are seronegative have what Blankschaen calls "exact justification." Since the test result is what establishes both the exact justification and the new sub-category among MSM donors, it also categorically insulates those MSM from the risk that The Empirical Case is trying to track.

Exact justification contrasts with what Blankschaen calls "ordinary justification." MSM donors have ordinary justification when they appeal to a variety of stand-ins to infer someone's serostatus instead of using a test to determine it. Ordinary justification insufficiently accounts for the elevated risk from The Empirical Case because it does not provide the right kind of evidence to support the belief that MSM donors do not pose a risk to a recipient. Start with self-assessment. Updating their 2012 review, a 2019 U.S. Preventative Services Task Force report estimated that 15% of the 990,000 people living with HIV in the U.S. (148,500) did not know that they were seropositive (Chou *et al*. 2019). Basing their findings on secondary infections, H. Irene Hall, David Holtgrave, and Catherine Maulsby concluded that about 49% of HIV transmissions were due to partners who were unaware that they had HIV (Hall, Holtgrave, and Maulsby (2012). So, unlike the deferral about feeling ill the day of the donation, we cannot know our serostatus based on how we feel because symptoms from HIV can sometimes take years to manifest. Introspection, then, is not just insufficient to determine our own serostatus, but it also insufficiently assures a recipient or sexual partner that we will not endanger them.

Similar mistakes show up during interpersonal decision-making. Social psychologists and public health experts found that sometimes MSM donors appealed to physical markers instead of tests in order to assess someone else's serostatus. Ariel Shidlo, Huso Yi, and Boaz Dali found that

while MSM used these physical markers in an effort to make sex safer, they nevertheless relied on spurious reasoning: “He is too young to have HIV,” “He looks too healthy to have HIV” (Shidlo, Yi, and Dalit 2005). Ordinary justification also shows up in other risk-management behaviors that try to reduce risk when MSM either do know their partner is seropositive or to guard against cases where a partner misreports his serostatus. Richard Wolitski explains that “strategic positioning” mitigates risk regardless of someone’s serostatus because “tops,” i.e. insertive men, are at less risk for sexually transmitted infections, including HIV, than “bottoms,” i.e. men who receive anal sex, are. In turn, safer sex practices like withdrawal reduce transmission risks regardless of sexual position (Wolitski 2005). All the same, the methods that characterize ordinary justification cannot preclude seroconversion (i.e. contracting HIV) in the way that MSM with exact justification can because ordinary justification can’t reliably inform someone about their partner’s (or their own) serostatus.

If we can differentiate MSM donors based on exact and ordinary justification, then we can recognize how someone can be MSM without also being exposed to the elevated risk from The Empirical Case. At the policy level, the MSM deferral is unjustified because it misclassifies MSM donors as a homogenous bloc and fails to correctly identify the behavioral condition that later tests are screening for. If MSM donors have exact justification, then they are unduly deferred. While I will analyze some of the risks that unduly deferred donors take on by lying in section four, I will close this section by defusing some concerns about non-compliance and recipient safety.

In section one, I worked through some of the reasons that we use donor deferral policies to safeguard the blood supply. If unduly deferred donors want to consider not complying with these policies, then, they need to justifiably believe that their non-compliance with the unwarranted policy does not pose any further risk to recipients. Identifying the ameliorative deferral conditions

for a policy defuses a moral concern about recipient safety. If an unduly deferred MSM donor has exact justification, then he has accounted for the ameliorative deferral conditions, which do a better job than the stated deferral conditions at tracking risk. Exact justification ensures unduly deferred donors that non-compliance does not produce additional risk. So, from a safety perspective, there is no reason an unduly deferred MSM donor should not donate if he has exact justification.

Granting the point about safety, there is another concern about selective non-compliance. As I showed in section one, the deferral policies only work if donors comply. Making the case that unduly deferred MSM donors are morally permitted to lie on one question casts an initial doubt on trusting donors to comply with the other deferrals. This doubt is misplaced for two reasons. First, unduly deferred MSM donors are not deciding on a whim to not comply. While I ultimately refrain from saying what the moral status of donating blood itself is, if someone decides to donate, then they incur a moral responsibility to recipients. The whole point of exact justification is to show how MSM donors justifiably determine if they are at an elevated risk. Using a HIV-test after a sufficient window period is not just in someone's own self-interest, it also establishes a moral concern for someone else, namely the recipient.

Second, one of the reasons that we can trust donors' answers to the deferral questionnaires is by emphasizing that recipients are the ones who bear the cost of faked results. Emphasizing recipient safety provides a unifying moral reason for unduly deferred MSM donors to honestly answer one deferral question while lying on another because the moral rationale for using deferral questions is recipient safety. Each answer the unduly deferred MSM donor gives aligns with that rationale. The prudential rationale for using deferral policies, that they conserve resources by preventing blood that later tests would remove anyways, would also not discourage unduly deferred MSM donors from lying either because exact justification already applied testing

standards that are equivalent to what will be used after the blood quarantine, so there is no reason to think that the donations are wasting resources.

Another concern about non-compliance is our general moral aversion to lying. Lying can be morally wrong for any number of reasons (e.g., it is disrespectful, it damages trust, it promises support that isn't there), but it can also be a lifesaving protection for ourselves or others (e.g., lying to stay in the closet, someone lying to an abuser that she is sheltering their victim). Unduly deferred donors present an unusual case because they are not really lying for personal gain and, unless it's a case of directed donation, they aren't really lying for the sake of a relationship. Moreover, by complying, unduly deferred donors are denying needed blood to recipients because unduly deferred donors are observing a policy that fails to account for the risks it says it does. While we might point to the moral damage lying to donate does to public trust in the system of safeguards, donating blood is largely a private affair and so an unduly deferred donor could go their whole life donating blood without anyone else knowing that they are donating while unduly deferred.[4] Nor could we easily claim that the lie damages the recipient's faith in the system of safeguards because the only reason the recipient should trust the system to protect them is if it is using evidence-based policies. Unduly deferred donors exist in the gap between the stated deferral conditions and the ameliorative deferral conditions. With the proper justification, unduly deferred donors do not pose a risk to recipients and so would not be infringing on that trust because the proper justification itself shows that the recipient's trust in the system of safeguards and stated deferral condition was misplaced. Even if an unduly deferred donor with exact justification was exposed or outed, that

[4] I bracket the separate, but important question of whether there is a moral obligation to publicly acknowledge the lie after the donation as a way to civilly disobey the unwarranted policy. Like revising deferral policies, this question is complicated and not just based on medical facts alone. Jose Medina notes that when we publicize acts of resistance, we create "emblems of resistance" for others to take up (Medina 2013, 234-49). This uptake depends on how sympathetic the person is, what the general public mood is for change, and if societal values unjustly code that resistance as heroic or deviant. (Cf. Dean Spade's criticism of relying on "perfect plaintiffs" (Spade 2015, 43-44).

exposure would only show the policy gap between the stated and ameliorative deferral conditions and if that damages the public confidence in the system, then that is an opportunity to correct it. Provided that unduly deferred donors have exact justification, lying to donate shows that non-compliance is less an issue of political subversion and more an issue of helping people in need under trying circumstances.

In the next section, I extend the distinction between exact and ordinary justification to the deferral about tattoos. I show that there is a slight policy gap between the stated and ameliorative deferral conditions about how tattoos are applied. I will make the case that while state regulations about how tattoos are applied make it more likely that safety measures are followed, the same kind of justification we rely on donors to have in states with regulations show up with donors in states that do not have regulations. Donors in unregulated states can, therefore, epistemically account for the risks they are allegedly exposed to.

3. Epistemic Obligations and Tattoos

Compared to the Haitian and MSM deferrals, there is relatively little written objecting to the FDA's tattoo deferral. Although numerous studies document how tattooing exposes people to an elevated risk of hepatitis B, C, and skin infections (Diekmann *et al*. 2016; Khodadost *et al.* 2017), many studies did not factor in how the venue or setting affected risk. More careful reconstructions of the data explain that hygienic precautions, which are common in professional tattoo parlors, preclude these risks (Hoad *et al*. 2019; Van Remoortel *et al*. 2019). Citing similar concerns about hepatitis, the FDA previously deferred donors who had had a tattoo applied in the previous twelve months "if the tattoo was applied by a state regulated entity with sterile needles and non-reused ink" (FDA 2018).

This deferral policy has mostly been unchallenged. Even tattoo activists seem to ignore policy critique and instead dedicate their efforts to debunking the myth that a tattoo automatically and indefinitely defers someone from donating blood.[5] As with the MSM deferral, the FDA revised its' tattoo deferral policy in 2020, reducing the deferral period from twelve months to three months. This smaller window period is a welcome step in the right direction, but nevertheless passes over the more fundamental question of whether the stated deferral condition accurately identifies what puts donors at risk. In turn, it ignores what unduly deferred donors should do in the meanwhile.

We can understand the stated tattoo deferral condition, about state regulated facilities, as deferring two kinds of facilities: (1) facilities that are not regulated, but in a state with regulations; (2) facilities that are in a state that does not have regulations. I'll work through each in turn. As we saw in section one, deferral policies are justified only if they identify behavior that typically exposes someone to health risks that are communicable to recipients. The stated tattoo deferral condition, then, is designed to guard against the unsanitary conditions typically found in facilities that are in a regulated state, but that do not follow those regulations.

Tattoos applied in prison, for example, typically happen in unsanitary conditions. While inmates have a constitutional right to health care, incarceration structurally shapes and limits their access. Overcrowding and close quarters in correctional facilities contribute to high rates of disease and illness (Nowotny 2017). In addition to any pre-prison vulnerabilities, (e.g., homelessness, drug use) inmates may be reluctant to seek medical attention because of administrative barriers (e.g., required copay, dual loyalty of staff as healthcare provider and correctional employee), or because explaining an injury may expose rule violation and potential further punishment (Binswanger *et al*. 2009). In 2013, the CDC estimated that one in three inmates in prisons or jails in the U.S. had

[5] Drew Thomas, for example, is a tattoo artist who organizes the annual Leave Your Mark blood drive to collect donations and raise awareness that people with tattoos can still donate (American Red Cross 2019).

hepatitis C (CDC 2013). Other studies corroborate similar infection rates, adding that "about half the prisoners may be unaware of their serological status" (Khodostat 2017, 2).

As I showed in section two, donors may take steps on their own to account for the risks associated with the stated deferral conditions. MSM donors with exact justification used tests to determine that they were seronegative and so not at additional risk to recipients. MSM donors with ordinary justification couldn't establish the same conclusion because they were trusting faulty markers or unreliable sexual practices. Even if inmates take prudential precautions to guard against hepatitis B, C, or other skin infections while in prison, these measures only provide ordinary justification. Commonly accepted "sterilization" measures (e.g., bleaching, boiling, heating instruments over an open flame) are not strong enough to kill viruses like hepatitis C. Given the unsanitary conditions in prisons, these measures insufficiently account for the risks that the stated tattoo deferral conditions are designed to track. On to the facilities that are in unregulated states.

While most states do regulate facilities, such as tattoo parlors, the policy misstates what puts tattooed donors at risk. Florida, for example, regulates tattoo parlors, while neighboring Georgia does not. People who get tattoos in Florida can donate blood after their donation, but people who get tattoos in Georgia must wait three months before donating blood. But state regulations aren't actually what protect people who get tattoos. What matters in terms of safety is if the workers in the facility observe the regulations. Analogously, states regulate how restaurants store, prepare, and cook food. Health codes promote customer health and make it more likely that restaurants abide by state regulations, but no one is immune to food poisoning or getting sick just because state regulations are in place. What matters is if the restaurant employees adhere to state regulations.

Suppose that Adrian goes to a tattoo parlor in Florida, but notices that the tattoo artist has not changed out the needle and is preparing to apply her tattoo. Adrian is not entitled to infer that she is not at risk for hepatitis or any other skin infections just because the tattoo parlor happens to be in Florida. Suppose, further, that a different, safer tattoo parlor adheres to Florida regulations for a decade and then re-locates to Georgia for tax reasons. Even though Georgia does not require the tattoo artists to apply tattoos according to any specified regulations, the staff could still hold themselves to the previous Floridian safety standards and so safely apply tattoos, even though they happen to be located in Georgia, an unregulated state. If the recently relocated tattoo artists still abide by the Florida safety regulations, then there is every reason to think that people who get tattoos from them in Georgia are just as safe as their previous clients were in Florida.

Writing effective policy is incredibly difficult. So, to be clear, I'm not contrasting Georgian and Floridian tattoo parlors to promote a "The FDA got it wrong again!" mentality. Rather, my point is that the other stated deferral conditions, sterile needles and non-reused ink, do track what puts tattooed donors at risk. Focusing on these other stated deferral conditions not only helps make the tattoo deferral more precise, it also identifies what unduly deferred donors need to learn before they consider non-compliance. While the current policy does defer donors who received tattoos in unhygienic conditions (e.g., prison), we can shift attention away from state regulations that may or may not be followed, to the conditions that make needle use generally unsafe (e.g., shared, not really sterilized). Rephrasing the tattoo deferral policy to ask donors about single-use needles would preclude tattoos applied in prison, include cases where parlors in a regulated state do not adhere to safety regulations, and include the typical cases where donors get tattoos in parlors that observe safety regulations, but just so happen to be in an unregulated state.

Focusing on the sanitary conditions around needle use helps reformulate the tattoo deferral policy, but recall that deferral policies are only effective if donors can self-sort based on the stated deferral conditions. If the above analogy about health codes in restaurants holds, then an effective reformulated deferral category is partly constituted by a behavioral condition (i.e. getting a tattoo) and an epistemic condition (i.e. assessing the sanitary conditions). As we saw in section two, this epistemic condition is morally important because having the proper justification is what accounts for the health risks associated with unsanitary needle use. If unduly deferred donors with tattoos meet this epistemic obligation, then they defuse the worry that their donation would endanger the recipient. While important, the epistemic obligation to assess sanitary conditions when a tattoo is applied is minimal. As with the current stated deferral conditions, donors with tattoos[6] in regulated states simply check to see if tattoo artists are wearing gloves, use a single use needle, and don't reuse ink. If these current standards are sufficient to safeguard donors with tattoos from hepatitis and other skin infections, then they would be equally sufficient under a reformulated policy.

If tattooed donors cannot meet this epistemic obligation, then they also cannot meet their moral obligation to not put recipients at additional risk. In this respect, if tattooed donors do not see evidence of sanitary needle use or if they get a tattoo in prison, then they face an epistemic quandary that prevents them from donating safely. Although HIV, hepatitis B, and hepatitis C feature prominently in concerns about unsanitary needle use, a tattooed donor could test for those conditions and so justifiably believe that she would not additionally endanger the recipient. The epistemic quandary, however, is that unsanitary needle use also exposes someone to a number of skin infections that would not be easy to account for. In this respect, a tattooed donor with ordinary

[6] While there is a (somewhat fluid) distinction between people with tattoos (i.e. people who get recreational tattoos that are easily concealable) and tattooed people (i.e. people who get tattoos that are readily visible as a sign of self-expression), nothing in my argument rests on the (sub)cultural or personal significance of tattoos (Roberts 2012). Since all that matters for my argument is how the tattoos were applied, I use the groups interchangeably.

justification about how safely their tattoo was applied is like the donor who feels unwell during the day of their donation: they are at risk for too wide an array of health risks to justifiably believe that their donation would not endanger the recipient and so it would not be morally permissible for them to donate while they cannot account for those communicable risks. After a sufficient window period, however, tattooed donors with ordinary justification would have let enough time pass for an infection to present and, given that it didn't, would become eligible to donate blood again.

We've seen three cases where a stated deferral condition fails to constitutively identify what puts donors at risk. I argued in section one that if deferral conditions do not accurately stand in for later health risks, then they are not justified. When deferral conditions do not accurately correspond to later tests, we either refine the deferral condition or we eliminate it altogether. This discussion tends to happen at the policy level because we are trying to figure out what the current policy should be. If, however, donors can reliably account for what the revised policy should be before that policy is re-written, and they do not violate that ideal policy, then they do not pose a communicable risk to recipients. Working through this point clarifies what unduly deferred donors are epistemically responsible for if they decide to not comply with an unjustified deferral policy. This epistemic obligation implicates a moral obligation: that donors minimize risks to recipients. Unduly deferred donors, then, are left with a choice to abide by a policy that fails to account for the risks it itself is trying to track or to lie on the donor questionnaires.

4 Lying in Blood

In this last section, I focus on some moral aspects of donating blood in general to make the case that when unduly deferred donors lie, they take on a material risk that other blood donors do not. If lying on the donor questionnaires is the only way for unduly deferred donors to donate

blood, and the lie is what exposes them to that risk, then, it is generally supererogatory for unduly deferred donors to lie in order to donate blood.

There is surprisingly little in the philosophical literature on the moral status of donating blood itself. Ethicists, researchers, and policy experts start from the premise that there is a blood shortage and then turn to particular proposals that would safely increase the blood supply. A common background premise in these discussions is that donating blood is something good to do, but not morally required. Arguments on the moral permissibility of financially compensating blood donors (sellers?), for example, do not make the argument that people have the moral duty to enter into the market, just that, under certain conditions, it is morally permissible for people to do so if they want to (Derpmann and Quante 2015). Comparisons between buying and selling blood and buying and selling plasma focus on the moral parity of those markets, not on if people have a moral obligation to participate (Farrugia, Penrod, and Bult 2010). Similarly, worries that buying and selling blood inappropriately commodify someone object to how someone provides blood, not if they are morally required to give it (Walsh 2015). The same is true of objections that markets in blood corrode our commitment to the common good (Archard 2002): even if commercialized exchanges diminish our sense of community, this concern does not say anything about a moral obligation to provide for the common good by donating blood.

Social and moral psychologists also pass over the moral status of donating blood, instead focusing on what motivates people to donate blood. These psychological discussions about blood donation explore the effects of financial and non-financial incentives to motivate donors (Chell et al. 2018) or how motivation changes over time with first-time donors and repeat donors (Lightman 1981, Piliavin, Evans, & Callero 1984, Sojka and Sojka 2008). While research has found that repeat donors tend to describe their reason for donating in in moral language, as feeling obligated

to help their community (Andre and Velasquez 1992), feeling obligated to do something is not the same as being obligated to do it. Further, these self-descriptions borrow language from special obligations or as an obligation that does not generalize to others because there is no follow-up criticism or wish that others would do their part and donate blood too.

I bring up this cursory literature review to note that there is a general background premise that donating (or selling) blood is morally good to do, but not morally required. Although I will introduce a recent and notable exception to that background premise that argues that donating blood is a moral obligation, I do not take a stand one way or another. I structure my argument about non-compliance as a disjunctive syllogism to show that in either case, if donating blood is supererogatory or if donating blood is morally required, then the same conclusion holds: since the only way for unduly deferred donors to donate is to lie on the questionnaires, and lying on the questionnaires exposes them to a material risk, then it is generally supererogatory for unduly deferred donors to lie in order to donate blood.

Supererogatory actions are those that are not required, but are good to do. J. O. Urmson points to saints and heroes as the most dramatic exemplars of supererogatory acts (Urmson 1958). Saints, for Urmson, do not have to be canonized or devoted to religion: they are saints when they dedicate themselves to others. Moral saints self-effacingly go the extra mile not by just giving their time, talent, or treasure to others, but by giving more than others could reasonably expect. Moral heroes are those who go above and beyond the call of duty by risking their well-being to ensure the safety of others. In his instructive example, Urmson describes a soldier who jumps on a grenade to save others in his platoon. The fact that the sacrificing soldier is a hero, but the others are not cowards, underscores that supererogatory acts exceed what duty requires. The take-away for our

purposes is that while moral saints and heroes provide some kind of good for others, we are not entitled to expect them to provide it.

But not every supererogatory act is a cinematic display of bravery or a single-minded life of giving. Urmson reminds us that "it is possible to go just beyond one's duty by being a little more generous, forbearing, or forgiving than fair dealing demands" (Urmson 205). Although these ordinary or everyday supererogatory acts do not merit the lofty titles of "saintly" or "heroic," Urmson is undoubtedly right that "cases of disinterested kindness and generosity," such as paying for a stranger's lunch or covering for a new coworker's error, exhibit the same features of the more striking examples: they are good to do, but not morally required (Urmson 205). These supererogatory acts make our lives go better, but we aren't entitled to them. To simplify the rest of the discussion, I'll use the language of saints and heroes to name two different vectors of supererogatory acts, where paying for a stranger's lunch ranks low on the saintly vector, but not at all on the heroic. *Mutatis mutandis* for taking on the new coworker's blunder.

In his seminal *The Gift Relationship,* Richard Titmuss developed a moral and sociological critique of commercialized blood markets (Titmuss 1970/1997). Titmuss worried that financial incentives would adversely influence the poor to give blood regardless of their health status: economic need and faulty self-assessment of health would outweigh concern for recipients. Another worry was that financial compensation corrupted the altruistic motives people had to help others. Instead, Titmuss advocated for a system entirely of voluntary and altruistic blood donors. Many of Titmuss' economic and sociological objections have not aged well, but his central thesis that donating blood is an altruistic gift has had conceptual longevity (Arrow 1972; Le Grand 1997; Sass 2013; Behrmann and Ravitsky 2013). Unlike other gifts between intimates or dictated by decorum, donated blood is almost always to a stranger who will never know the donor and whom

the donor will never know. This anonymous gratitude fosters a deep sense of solidarity within communities, especially during large-scale tragedies,[7] because people are coming together for those they do not know and for no other reason than those affected are in need.

Framing blood as an anonymous gift to an anonymous recipient underlines that donating blood is an entirely voluntary act. Titmuss reasoned that without financial incentives as motivation, donors freely decide to donate blood because they want to do good. We can, therefore, extrapolate two salient features from the Gift Model: (1) people are neither required nor expected to donate blood; (2) the act of donating blood offers recipients a moral good that improves their welfare. Together, these two features indicate that donating blood registers on the lower, saintly vector of supererogatory acts because it involves a small sacrifice for others of time and blood, and that is good to do, but not morally required.

In contrast to the Gift Model, Paul Snelling (2014) inveighs that donating blood is not supererogatory, but morally obligatory. Acknowledging that marketing rhetoric supports The Gift Model, Snelling utilizes Peter Singer's (1976) influential criticism of donating money: contrary to popular belief, Singer maintains that donating money to the global poor is not a voluntary act of charity, but morally required for life-saving aid. Snelling advances a parallel argument about the moral status of donating blood:

(1) Suffering and death from lack of donated blood are bad.

(2) If it is in our power to prevent the suffering and death in (1) without also sacrificing something that is equally morally important, then we are morally obligated to do so.

[7] Dov Fox (2010) argues that preventing MSM from donating blood in times of need contributes to a larger message that gay men are not fully integrated or accepted into society, especially because the policy has the added weight of federal approval. Galarneau (2010b) provides a more general discussion about how preventing marginalized groups from donating blood during times of crisis exacerbates their marginalization.

(3) By donating blood, we can prevent the suffering and death in (1) without sacrificing something that is as morally important.[8]

(4) Therefore, we have a moral obligation to donate blood to prevent suffering and death in (1).

Snelling acknowledges that the conclusion is stunning. Even if we end up living out a weakened version of the conclusion,[9] that we are not obligated to rush off every time our blood replenishes to a safe level to donate, it would radically change how we would live. More to his point, accepting a weakened version of Snelling's conclusion would radically change the fact that others would stay living.

Recall that we are concerned about the moral status of lying in order to donate blood. I'll work through a real-world example to show that whether donating blood is supererogatory or a moral obligation, it would be supererogatory for unduly deferred donors to lie in order to donate because the act of donating requires them to not comply with a deferral policy. If non-compliance exposes an unduly deferred donor to severe financial risk, then any act of donation would mean that unduly deferred donors are doing something that registers on the lower side of the hero vector.

Between 1990 and 2002, Kyle Freeman donated blood nineteen times. Using Canadian Red Cross Society (CRCS) and, later, Canadian Blood Services (CBS), Freeman was required to answer a donor questionnaire each time he donated blood. At the time, both CRCS and CBS adhered to an indefinite deferral policy for MSM who had been sexually active with a man since 1977.[10] Relying on previous testing to determine that he was not at risk for HIV, even though he

[8] If people who are terrified of needles would suffer worse than the recipient who needs blood to live, then they would be sacrificing something that is morally comparable to the suffering in (1).
[9] Cf. Travis Timmerman's critique of why this kind of argument permits us to occasionally not meet this obligation (Timmerman 2015).
[10] This policy has since been revised to a five-year deferral in 2013 and a one-year deferral in 2016.

was MSM, Freeman lied each time he donated blood. Then, in mid-June of 2002, Freeman anonymously e-mailed CBS to protest that their MSM deferral was discriminatory, hinting that he had misrepresented his MSM status in previous donations in a follow-up email. A few days later, Freeman donated blood through CBS, who later contacted him to inform him that his blood tested positive for syphilis. Shortly thereafter, and with the help of a court order, CBS determined that Freeman had sent the anonymous email and began removing his blood from their storage facilities. In a complicated legal battle that ended in 2010, the Ontario Superior Court found Freeman guilty of negligent misrepresentation and ruled that he was liable to CBS for (CA) $10,000 (US $9,648).[11]

There is a lot happening in this case, but I want to focus on the outcome, that Freeman was liable for (CA) $10,000. Freeman was convicted of negligent misrepresentation, of exposing others to undue risk, because he has misrepresented that he was MSM. But given that only Freeman's most recent donation actually posed a danger to recipients, his previous donations didn't endanger anyone. CBS had, presumably, tested the earlier donations and determined them to be safe—why else would they hold on to the blood? Removing the blood after the testing, after finding out that Freeman was the one who sent the anonymous email and previously lied on the MSM portion of the questionnaires, was, from a safety perspective, unnecessary.

So why remove the blood? Why not just keep the non-compliance quiet by discreetly blacklisting Freeman from donating blood in the future? One likely concern was that if Freeman told CBS about his non-compliance, then he might further publicize it and the attempt to suppress it. Another reason to pursue charges against Freeman would be to reassure recipients and the public that while no medical system is flawless, CBS was willing to take corrective steps that removed any dangerous blood from their storage facilities that unfortunately slipped through the system of

[11] For a more detailed overview of the trail and Freeman's own (convoluted) testimony, see Canadian Blood Services/Societe Canadienne du Sang v. Freeman, 2010

safeguards. Further, punishing Freeman with a steep financial fine, initially seeking (CA) $100,000 worth of damages, would also send a message to other Kyle Freemans who were thinking about non-compliance. Making a punitive example out of Freeman added to the assurance that the system's integrity remained intact because it showed that there were enforcement mechanisms in place. One last likely reason that CBS removed the blood that they had already tested and determined to be safe was that if CBS had kept Freeman's prior donations, then they would be tacitly admitting that the very deferral policies that they had in place to protect recipients were not, in fact, providing protection. Not in the sense that Freeman's prior donations had "infiltrated" the blood supply, but that CBS was seeing risk where there was not any. By acknowledging Freeman was a MSM donor at the time of his prior donations, his blood should have been deferred as at-risk. And yet, because of the sheer volume of his previous donations, there was ample evidence that Freeman was MSM without also putting recipients at further risk from being MSM. If the policies exist for the sake of the recipients, then the unexpected exposure could have been an opportunity to publicly review the policies and reassess what, exactly, put MSM donors at risk rather than trying to restore faith in the system by retribution.

Now, most of us don't have the (CA) $10,000 that the court awarded CBS. Whether unduly deferred donors are caught or not, their intentional non-compliance exposes them to a substantial risk, namely paying (CA) $10,000. So, let's suppose that donating blood is a supererogatory gift. Like other donors, unduly deferred donors would not be doing anything additionally saintly when they donate: they would not be sacrificing more blood nor would they be giving up more of their time to donate. But, if Freeman's case is indicative of anything, then unduly deferred donors take on a risk that other donors do not because donor non-compliance is what exposes unduly deferred donors to the substantial financial risk that Freeman was liable for. Peter French points out that

these kinds of risks are exactly what separate the heroic from the good (French 1992). Heroes recognize and take the necessary risks to their own well-being for the sake of protecting or saving others. In this respect, then, the unduly deferred donor does something that registers on the saintly vector when they donate blood and they do something that registers on the heroic vector when they lie because the lying is what exposes them to financial danger and that lie is for the sake of helping others.[12]

Suppose, however, that donating blood is morally obligatory. Depending on someone's financial situation, the concern about (CA) $10,000 might be morally comparable to the suffering from lack of blood and suspend the obligation to donate that Snelling identified. If an unduly deferred donor decides to risk the financial penalty, then the only way that she could donate blood would be if she lies on the donor questionnaire: answering truthfully would result in deferral. Lying on the questionnaire is what exposes unduly deferred donors to the substantial risk. If the lying is what exposes unduly deferred donors to the risk, then they are exposed to a danger that other donors are not, even though they are performing the same act of donating blood. But, as we just saw, heroic actions are not only measured by the good they do, but by the risk the hero takes on. Adapting an example from Alastair Norcross, if Firefighter A can save ten people by remotely pushing a button that unlocks the doors in a burning building, then he does good, but he hasn't done something heroic because button pushing isn't especially dangerous. If Firefighter B can save ten people by going into an especially dangerous inferno, then she has done something heroic because the rescuing exposes her to danger (Norcross 1997). If, then, the heroic act is required to

[12] This conclusion depends on typical cases where, I take it, unduly deferred donors do not have (CA) $10,000 to spare. If a one-percenter lies to donate and is exposed to the same punishment, their action may not be heroic because the rest of their wealth insulates them from the risk.

perform a moral obligation, then the morally obligatory thing would have to, in fact, also be supererogatory, because it cannot be done without doing something that is supererogatory.

One objection to this line of thought is that just as heroic actions depend on the hero taking risks, so too does it depend on not endangering the person rescued. If the deferral policies classify potential donors in terms of whether they pose a risk to recipients, and lying on the donor questionnaires disregards the precautions from the deferrals, then an at-risk donor who lies on the questionnaires endangers the recipient, undercutting the moral good that they provide. But this objection only works if the donor actually endangers the recipient. Identifying the ameliorative deferral conditions identifies what puts potential donors at risk to recipients. When a deferral policy misstates that risk, then unduly deferred donors have an epistemic and moral responsibility to account for these ameliorative deferral conditions before they decided to donate. Once potential donors met these responsibilities, they are justified in believing that they are not at risk to recipients and could then go on to decide if they wanted to take the risk and lie on the donor questionnaires.

Another reason to pause revisits the general aversion to lying. Presumably, there is an even stronger aversion to praising lying as heroic. Acknowledging this general moral aversion to lying, Jennifer Saul urges us to consider what lying shows about someone's character in difficult moral situations (Saul 2012). Unduly deferred donors face a difficult choice: either comply with a deferral policy that does not account for the risk it claims to and so deny needed blood to recipients or deliberately not comply by lying and so risk financial penalty. The motivation is to provide recipients with needed blood and presupposes that unduly deferred donors have met the epistemic and moral obligations to determine that they are not at risk. The fact that unduly deferred donors would be willing to take this risk to help someone they will likely never know suggests bravery, not duplicity. Furthermore, there are cases where lying was heroic. Although they all later claimed

that they did what anyone else would have in their situation, Miep and Jan Gies, Victor Kugler, Johannes Kleiman, and Beb Voskuijl knew that they were taking a tremendous risk when they lied to their coworkers and Nazi officials that they were hiding Anne Frank and her family. My point is only that there are some extraordinary cases where lying takes on heroic aspects.

One final worry might be that lying to donate blood is morally unlike lying to protect the Franks. The Franks' friends could point to the particular lives they were saving as a justification for overriding our general prohibition on lying. In typical cases of blood donation, however, donors give anonymously to a blood bank that doesn't identify the specific lives at risk, which complicates how we justify lying. This worry is misplaced. In the early 1990s, the military junta in Myanmar increased its persecution of the Rohingya, encircling areas and restricting what could brought to the beleaguered refugees. Suppose a monk learns about a drop point inside the restricted area and wants to help by smuggling in food and medicine under a fake story about needing to pass through the area on pilgrimage. At the checkpoint, the soldiers ask him if he has any prohibited items (e.g., food and medicine). If the monk answers honestly, he will suffer reprisals and not help anyone, so he lies and gets a temporary pass, having to report to the next army station by the end of the day. The monk happens upon someone at the drop point who collects the supplies and promises him that someone will benefit from his donation (even though the monk will never know who). Here, it seems that the monk is taking a substantial risk for people he cannot identify. By lying, the monk is doing something supererogatory for the besieged Rohingya because he is taking on a risk that others could not reasonably expect him to take on. Being able to identify the particular lives at risk, then, may help draw out motivating details to take a material risk, but it is not necessary to override the general moral prohibition on lying or to act heroically.

Conclusion

I've argued that deferral policies are only justified when they correctly identify conditions that stand in for later health risks to recipients. If these stated deferral conditions misdescribe what puts donors at risk, then they unduly defer donors who do not pose a risk to recipients. Although we should ultimately aim at policy revision so that more people are safely eligible to donate blood, I have made the case that efforts to improve deferral policies have to identify the conditions that actually expose donors to risk. By that same fact, these ameliorative deferral conditions point to what unduly deferred donors are morally and epistemically responsible for when they decide to donate blood. Since the deferral policy has not yet adopted the ameliorative deferral conditions, the only way unduly deferred donors can donate blood is by lying. This lie exposes unduly deferred donors to a substantial financial penalty and so, I concluded, makes the act of lying to donate blood supererogatory.

So, where does this conclusion leave unduly deferred donors? Should MSM and recently tattooed donors with exact justification lie on donor questionnaires to donate blood or not? That decision is up to them. I've argued that donating blood is a conditional obligation, so this question only makes sense if an unduly deferred donor decided to donate in the first place. In that respect, my arguments are meant to clarify what that decision-making process entails and remove some of the conceptual obstacles that unwarrantedly discourage unduly deferred donors from thinking that donating blood is even a viable option.

Working through the ameliorative deferral conditions draws out what unduly deferred donors are responsible for learning when they commit to donating blood and how they can learn that information. These epistemic obligations point to a moral concern for others, which in turn defangs worries about endangering recipients. But there is more than concern for others at stake. Constraining circumstances necessitate that unduly deferred donors can only donate if they lie,

which is what exposes them to a steep financial risk. By arguing that lying to donate blood is supererogatory we can alleviate much of the moral reservation that unduly deferred donors may feel about lying when they are confronting limited choices: comply with a policy that misclassifies them as a risk and so deny recipients safe blood or lie, donate blood, and open themselves up to reprisal. My point is not how unduly deferred donors should respond to the risks, responsibilities, and good they can do by lying. As I noted in the beginning of this paper, we have largely passed over the issue of what unduly deferred donors should do until the policy changes to let them donate blood. This neglect presumes that compliance is sufficiently appropriate. My point, therefore, is that compliance is not the only, automatic, or obvious outcome when unduly deferred donors want to donate blood.

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